has been tapered to 15 mg every other day, and she has continued to do very well clinically.

Recent publications have emphasized unusual presentations of polymyalgia rheumatica and temporal arteritis.[2,3] The above case shows that even the more traditional presentations can vary from patient to patient. A literature search has failed to find previous reports of palindromic or asymmetric polymyalgia rheumatica. Further definition of these variations and their frequency may be useful in allowing patients to receive therapy for this eminently treatable disorder.

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Women in House Staff Training Programs

TO THE EDITOR: Recent reports[1,2] have described the increased impact of women physicians in medicine. We would like to add another dimension to this reported experience by noting the prevalence of women in the house staff training programs at the Kaiser-Permanente Medical Center in Santa Clara, California. This hospital is part of Stanford University's affiliated programs for graduate medical education in pediatrics, general surgery and the surgical specialties, and has independent programs in obstetrics and gynecology and internal medicine (affiliated for medical student teaching).

The medical house staff consists of 22 full-time residents, 4 first-year residents in psychiatry from Stanford University, who spend six months on medicine, and a chief medical resident. Of the 22 full-time medical residents, 18 (82 percent) are women. Of this year's entering residents, 100 percent (all eight) are women. Women make up 44 percent (four of nine) of the obstetrics and gynecology house staff.

We can only speculate on the reasons for this prevalence. Chance probably is one factor. Another might be the noncompetitive and strong clinical orientation of the programs, or the flexible structure of the medicine program, which also allows considerable time for personal needs (night call every fifth night and a night float system, for example).

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Iron Deficiency Therapy and General Nutrition

TO THE EDITOR: We commend the interesting and thorough paper "Iron Deficiency: Diagnosis and Treatment"[1] by Dr. Peter R. Dallman in the June 1981 issue. We would add only two precautionary notes from a nutritional point of view. First, iron therapy can affect the absorption of other essential nutrients[2] and for this reason should be lowered when the anemia is eradicated and discontinued as soon as the patient's iron stores are deemed adequate. Second, it must be remembered that the dietary recommendations in Dr. Dallman's paper pertain to patients with clinical problems and are not appropriate for the healthy, normal population. (For example, to limit dairy foods with an eye towards enhancing iron absorption would, in a person not at iron risk, limit access to calcium, riboflavin, and vitamins A and D, nutrients not abundantly available in our food supply otherwise.)

Dietary recommendations limiting the intake of any of the basic four food groups during iron therapy should be discontinued as soon as the iron deficiency has been eradicated, and the complete exclusion of any major food group during iron therapy should definitely be discouraged.

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Competition and Professionalism

TO THE EDITOR: There is an increasing feeling of uneasiness in the current attempt to indoctrinate the practitioner with economic guideposts to his professional conduct. Such erosion of professionalism is implicit in a cold dollar-centered judgment of medical care—a judgment that does not reflect

the public's preferred goal of a worthwhile life with good health. Subtle indoctrination, which encourages a shift away from the conduct of a professional who is meant to tend the ill to a man whom the economists counsel to tend the cash register for society, should be viewed with concern.

Practitioners should, of course, be accountable where waste and inefficiency surface. The move from the hospital back to the office for appropriate diagnostic and surgical procedures is part of such accountability (despite the increased malpractice liability). Furthermore, the move away from the costly emergency rooms exposes the economic and medical fallacies of the mandatory specifications from the Hill-Burton bureaucracy for such service.

The recent emphasis on the cost-benefit relationship derives from the bureaucratic concept of medical care as an industry or business. Few will deny that the legislative component of the government has been and so far continues to be a significant part of the problem of the high cost of patient care. The thought occurs that a rudimentary political medicine is being worked out from heretofore ruinous political economics, oblivious of the conflict between price and medical efficacy.

The economists' inroads into patient care are justified on the grounds that there is a similarity in market procedures to medical care and commercialism. There is, of course, a limited role for the market in medical care—for example, supplies, food, laundry, armamentaria, maintenance and nonprofessional labor. No activity, commercial or professional, can subsist without some such requirements. The elemental fact, however, remains that the material, the product and the result are not comparable.

Competition, currently being promoted as the key to cost containment of medical care (as noted in the editorial "Competition in the Health Care Enterprise"[1] in August), is of two kinds: (1) *professional,* involving skill and competence, and (2) *price,* widely popularized by Professor A. C. Enthoven, whose discipline (economics) by its very nature is relevant to the commodities market but not to patient care. Our deepest concern that it is unprofessional to compete in price, long held as the foundation of all professionalism, was singled out for legal disapproval by judges unsure of its meaning and justification. (Witness the admission in a footnote to a 1975 Supreme Court decision that "professional practice was different from other [sic] business activity."[2])

Price competition is germane to commercial ventures, not professional conduct. There is a proper place for pluralistic medical care approaches to satisfy various tastes and needs. However, when the burden of participating in such ventures (with pressures exerted for cost containment) is placed upon the medical profession, there is some ground for the conclusion that it constitutes an inroad of commercialism into professionalism with what I believe to be a further deprofessionalization of the profession.

Underneath all the jargon of competition, the old truism "you get what you pay for" seems forgotten. Implied in it lies conservation—reducing the consumption of medical care to contain its cost. But what you end up with is cost-shifting; from the government, insurer and employer to the patient. The theory presupposes that if you are to pay for something from your own pocket you will shop or forego the service. That is true for commercialism, but when it comes to life and health, the human odds in most cases are against such a supposition. Note the testimony of "shoppers" from prepaid group plans. Cost reduction can be made to look good on paper, but when all the costs are added up, you will still come up with virtually the same figures for cost of medical care.

There is a direct correlation between cost and scientific and technological achievements; hence, the expectation of a solution to the high cost through competition remains to be seen. Such expectation is further in doubt through the paradoxical suggestion of controls on quality and accessibility—a costly governmental regulation that runs counter to the mood of the country in last year's election.

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Chinese Medicine

TO THE EDITOR: Eloquent truths are so often unconsciously spoken. This was brought home to a group of us on a recent trip to China during which we were given the opportunity to observe how Chinese medicine is practiced in their hospitals. As we passed from room to room we saw patients undergoing various forms of treatment. Some were subjected to cupping, others had warm paraffin packs on their abdomens for the treatment of